

CHAPTER 7-000 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

7-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), providers shall complete and sign Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90), and submit the completed form to the Department for approval. Providers participating in NMAP shall meet any applicable state and federal laws governing the provision of their services.

NMAP does not generally enroll hospitals, long term care facilities, rehabilitation services or centers, physicians, and other licensed practitioners as providers of durable medical equipment, medical supplies, orthotics and prosthetics.

NMAP enrolls, as providers of durable medical equipment, medical supplies, orthotics, or prosthetics, only those providers who are involved in the direct provision of services or items to the client.

7-002 Covered Services: NMAP covers medically necessary durable medical equipment, medical supplies, orthotics, and prosthetics, which meet program guidelines when prescribed by a physician (M.D., D.O., D.P.M.).

7-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

7-002.01A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

7-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. For services which require NMAP prior authorization (see 471 NAC 7-008.01), the provider shall contact the PCCM plan and request authorization as directed by the plan. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

7-003 Non-Covered Services: NMAP does not cover items which primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, and new equipment of unproven value, and equipment of questionable current usefulness or therapeutic value.

This Chapter's coverage index, although not intended to be all inclusive, specifies items which are generally not covered by NMAP (see 471 NAC 7-013).

7-004 Definitions: NMAP uses the following definitions -

Bed-confined: The client's condition is so severe that the client is essentially confined to bed, although not necessarily 100 percent of the time.

Custom fabricated: Made for a specific client from his/her individualized measurements and/or pattern.

Custom fitted: Substantial adjustments are made to a prefabricated item by a specially trained professional to meet the needs and/or unique shape of an individual client. Casting or molding techniques are not used in fabrication.

Durable Medical Equipment (DME): Equipment which -

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client's home. This does not generally include nursing facilities and ICF/MR's.

Homebound: The client's condition is such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration or are attributable to the need to receive medical treatment.

Medical Supplies: Expendable or specified reusable supplies required for care of a medical condition in the client's home. This does not include personal care items (e.g., deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc.) or oral or injectable over-the-counter drugs and medications.

Molded to patient: Direct molding on the involved portion of a client's body. This material is ultimately used in the device being fabricated.

Molded to patient model: A process in which an impression is made of the specified body part. This impression is used to make a positive model (usually plaster) of the body part. The orthosis is then custom fabricated and/or fitted using this model.

Orthotics: Rigid or semi-rigid devices to prevent or correct physical deformity or malfunction, to support a weak or deformed part of the body, or eliminate motion in a diseased or injured part of the body.

Prosthetics: Devices to replace a missing body part.

Room-confined: The client's condition is such that leaving the room is medically contraindicated.

7-005 Services for Clients Residing in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's): NMAP covers only the following items for clients residing in nursing facilities and ICF/MR's, if the client's condition meets the coverage criteria for the item as outlined in 471 NAC 7-013 -

1. Air fluidized bed units and low air loss bed units;
2. Augmentative communication devices/accessories;
3. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use;
4. Supports (elastic stockings, trusses, etc.) as defined in this Chapter, excluding surgical/anti-embolism stockings;
5. Orthoses (lower and upper limb, foot, and spinal) as defined in this Chapter;
6. Prostheses (breast, eye, lower and upper limb) as defined in this Chapter;
7. Oxygen and oxygen equipment, if the client's prescribed need for oxygen meets the minimum liters per minute (LPM) and hours per day as outlined below:

<u>Minimum</u>		<u>Minimum</u>	
<u>LPM</u>	<u>Hours Per Day</u>	<u>LPM</u>	<u>Hours Per Day</u>
1.5	24	3.5	9
2	14	4	8
2.5	12	4.5	7
3	10	5	6

8. Repair of medically necessary, client-owned durable medical equipment otherwise covered for clients residing in nursing facilities and ICF/MR's; and
9. Parenteral nutrition solutions and additives.

All other items necessary for the care of clients residing in nursing facilities or ICF/MR's are included in the payment to the facility and cannot be billed directly to NMAP.

7-005.01 Prior Authorization Requirements: Services for clients residing in nursing facilities and ICF/MR's follow the prior authorization requirements outlined in 471 NAC 7-008.

7-005.02 Billing Requirements: When billing for services provided to clients residing in nursing facilities and ICF/MR's, the provider shall use the appropriate place of service code.

7-006 Services Provided to Hospital Patients: Hospital patients are defined as registered inpatients and outpatients of a hospital, including a rehabilitation hospital, for the primary purpose of receiving medical services. Durable medical equipment, medical supplies, orthotics and prosthetics (including fittings) provided to hospital patients may be provided directly by the hospital or under arrangements with a non-hospital supplier/provider. Payment is made to the hospital according to the Medicaid reimbursement methodology for hospital services. EXCEPTION: In the event a customized wheelchair for primary use in OTHER than the hospital setting is needed for training purposes while the client is a hospital inpatient, the non-hospital supplier/provider may deliver the wheelchair to the client during the inpatient stay and bill NMAP. This exception does not apply to other items provided for use in the hospital setting.

7-007 Documentation of Medical Necessity: The provider shall obtain written documentation from the prescribing physician which justifies the medical necessity for durable medical equipment, medical supplies, orthotics and prosthetics and related services provided. The original documentation of medical necessity must be kept on file by the provider. The documentation must -

1. Be signed by the physician's own hand (stamps or other substitutes may not be used) and dated, using the date the documentation is signed;
2. Specify the start date of the order if the item is provided before the date the documentation is signed;
3. Include the physician's name, address and telephone number;
4. Include the diagnosis and/or condition necessitating the item(s) and an estimate of the total length of time the item will be needed (in months or years). The estimated total length of time the item will be needed must be completed by the physician or physician's office staff;
5. Be sufficiently detailed, including all options or additional features which will be separately billed or will require an upgraded procedure code;
6. Describe the ordered item(s) using either a narrative description or a brand name/model number, including all options or additional features (this may be completed by someone other than the physician, but the physician must review the order and sign and date it to indicate agreement);
7. For supplies provided on a periodic basis, include appropriate information on the quantity used, frequency of change and duration of need (PRN or "as needed" may not be used); and
8. Include information substantiating that all NMAP coverage criteria for the item(s) are met.

7-007.01 Medicaid Certification of Medical Necessity Forms: Use of the following Medicaid Certification of Medical Necessity (CMN) forms is required. Form examples and completion instructions are included in the Medicaid Provider Handbook -

Form MS-78, "Augmentative Communication Device Selection Report"
Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report"
Form MS-80, "Air Fluidized and Low Air Loss Bed Certification of Medical Necessity"

7-007.02 Medicare Certification of Medical Necessity Forms: Use of Medicare CMN forms, when a specific Medicaid CMN form does not exist, is strongly encouraged. When using Medicare CMN forms, Medicare completion instructions apply. Use of the following Medicare CMN form is required -

Medicare "Attending Physician's Certificate of Medical Necessity for Home Oxygen" form
(latest revised edition)

7-007.03 Recertification of Medical Necessity: Documentation of medical necessity must be updated annually or when the physician's estimated quantity, frequency or duration of the client's need has expired, whichever occurs first, unless otherwise specified in this Chapter's coverage index.

7-007.04 Second Opinion: NMAP may request a second opinion to document medical necessity.

7-008 Prior Authorization

7-008.01 Prior Authorization Requirements: Prior authorization is required for payment of rental and purchase of the items listed below. Note: Prior authorization is not required for payment of Medicare coinsurance and deductible.

1. Car seats;
2. Communication devices and accessories;
3. Hospital beds, electric;
4. Nebulizers, ultrasonic;
5. Oximeters;
6. Pressure reducing wheelchair cushions only for clients residing in nursing facilities and ICF/MR's;
7. Seat lift chairs;
8. Spinal orthosis seating systems and back modules incorporated in or attached to a wheelchair base;
9. Transcutaneous electrical nerve stimulators (TENS);
10. Ultraviolet cabinets;
11. Vehicles, power operated (POV's);
12. Wheelchair bases;
13. Wheelchair options/accessories, when part of rental or initial wheelchair purchase;
14. Whirlpools;
15. NOC (not otherwise classified) durable medical equipment - ONLY when the purchase price of the item exceeds \$500; and
16. Any item for a client whose condition does not meet the NMAP coverage criteria for the item.

7-008.02 Requests for Prior Authorization: The provider shall submit requests for NMAP prior authorization electronically using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transaction Instructions at 471-000-50) or by completing and submitting a clear reproduction of Form MS-77 to:

Durable Medical Equipment Program Specialist
Medicaid Division
Nebraska Department of Health and Human Services Finance and Support
P.O. Box 95026
Lincoln, NE 68509

A full-sized copy of Form MS-77 is included in the Medicaid Provider Handbook (see 471-000-206 for an example of the form and completion instructions).

The provider shall submit the documentation of medical necessity as outlined in 471 NAC 7-007 with each prior authorization request.

The Medicaid Division shall review the prior authorization request and documentation. The Department will notify the provider of the coverage decision on Form MS-77, "Prior Authorization Request", or the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or if additional information is needed, the specific information will be requested.

7-008.03 Prior Authorization Limitations: Approved prior authorizations are valid only if -

1. The client is Medicaid-eligible at the time services are provided. It is the responsibility of the provider to verify the client's Medicaid eligibility for the date of services;
2. The client's condition meets the NMAP coverage criteria for the item at the time of purchase or for the duration of the rental period;
3. For rentals, the item is used appropriately by the client for the duration of the rental period;
4. The client's living arrangement does not change. Movement to a nursing facility, ICF-MR or hospital may invalidate an approved prior authorization;
5. The client is not enrolled in an NHC HMO plan at the time the service is rendered; and
6. All other NMAP policies are followed.

7-009 "Coordination Plan" Requirement for Certain Services: A "Coordination Plan" is an overall program outline for the delivery of a specific service; it is not an individual patient care plan. The following services will be reimbursed only to providers with approved "Coordination Plans"-

1. Air fluidized bed units;
2. Apnea monitoring services;
3. Low air loss bed units;
4. Phototherapy services; and
5. Uterine monitoring services.

A separate "Coordination Plan" is required for each type of service provided. The "Coordination Plan" must be submitted to and approved by the Medicaid Division prior to providing the service and must include -

1. A request for review of the "Coordination Plan" which includes the provider's name, address, phone number, contact person, and Medicaid provider number;
2. An overview of the services provided, including the provider's charge for the services;
3. Descriptions and literature on the equipment and all supplies and accessories provided;
4. Copies of all forms instructions, and record sheets for client use;
5. An outline of the training format used to train client on use of equipment and other training requirements (e.g., infant stimulation/resuscitation for apnea monitoring services);
6. The type and frequency of client contact (home visits, assessments, consultations, telephone follow-up, etc.) and identification and qualifications of personnel conducting client contacts; and
7. A statement of the provider's policy on equipment set-up, servicing, and availability for consultation on equipment problems.

After review of the "Coordination Plan, Medicaid Division staff shall notify the provider in writing of the "Coordination Plan" approval or disapproval.

The provider must notify the Medicaid Division of any changes in the "Coordination Plan".

7-010 General Coverage Requirements and Limitations:

7-010.01 Coverage Criteria: Criteria for NMAP coverage of durable medical equipment, medical supplies, orthotics and prosthetics is outlined in this Chapter's coverage index (see 471 NAC 7-013). Items not specifically listed may not be covered by NMAP. In order to be covered by NMAP, the client's condition must meet the coverage criteria for the specific item. Documentation which substantiates that the client's condition meets the coverage criteria must be on file with the provider (see 471 NAC 7-007 for documentation of medical necessity requirements).

Exception: Some items of equipment may be covered under certain conditions even though they do not meet the exact definition of durable medical equipment. These items may be approved only by the appropriate staff of the Medicaid Division. To be covered, the equipment must prevent frequent hospitalizations or institutionalization, or serve a therapeutic purpose in an individual case. Use of these items must be included in the physician's course of treatment and be supervised by him/her.

7-010.02 Legend Products: Products which carry the federal caution label (e.g., "CAUTION; Federal (U.S.A.) law prohibits dispensing without prescription") are payable only to pharmacy providers.

7-010.03 Maximum Quantity for Supplies: The maximum allowable quantity of supplies that may be dispensed is limited to a three (3) month supply, unless otherwise specified in this Chapter's coverage index (see 471 NAC 7-013).

7-010.04 Multiple or Duplicate Items: NMAP does not cover purchase, rental or repair of multiple or duplicate durable medical equipment, orthotics or prosthetics used for the same or similar purposes (e.g., power and manual wheelchairs, two nebulizers for use at different locations, etc.) NMAP does not cover back-up equipment. Back-up equipment may be supplied by the provider, but the provider may not bill NMAP.

7-010.05 Replacement: Replacement of medically necessary, NMAP-covered durable medical equipment, orthotics and prosthetics owned by the client is covered if needed due to change in the client's medical condition, wear, loss, irreparable damage, except for malicious damage, culpable neglect or wrongful disposition. Replacement required due to malicious damage, or culpable neglect, or wrongful disposition should be referred to the Medicaid Division for review.

7-010.06 Repair: NMAP covers repair required for the effective use of durable medical equipment, orthotics, and prosthetics when -

1. The item is covered by NMAP;
2. The client's condition meets the coverage criteria for the item; and
3. The item is owned by the client.

The cost of the repair may not exceed 80% of the NMAP allowable purchase price for the item. Payment for labor charges is covered only in conjunction with repair. All manufacturer and provider warranties must be pursued. Repairs required due to malicious damage or culpable neglect should be referred to the Medicaid Division for review.

NMAP covers rental of covered durable medical equipment for a maximum of three (3) months during which time the client-owned equipment is being repaired. If at any time the provider's usual business practice is to provide loaner equipment at no charge, the provider shall not bill NMAP for rental during that period.

When billing for repair of durable medical equipment, the provider shall indicate if the item repaired is client owned.

7-010.07 Orthoses and Prostheses: NMAP payment for orthoses and prostheses includes -

1. Evaluation;
2. Fitting;
3. Cost of parts and labor;
4. Repairs due to normal wear and tear for a minimum of 90 days from the date dispensed; and
5. Adjustments made when fitting and for a minimum of 90 days from the date dispensed when the adjustments are NOT necessitated by changes in the client's medical condition (e.g., residual limb) or the client's functional abilities.

Orthotic/prosthetic evaluations are reimbursable only when no device, orthosis, prosthesis, part, repair or adjustment is provided.

7-010.08 Supplies/Accessories for Durable Medical Equipment: Supplies and accessories required for the proper functioning and effective use of durable medical equipment are covered when -

1. The equipment is covered by NMAP;
2. The client's condition meets the coverage criteria for the equipment; and
3. The equipment is owned by the client.

Supplies and accessories for rented durable medical equipment are generally included in the NMAP rental payment, unless specifically allowed as outlined in this Chapter's coverage index.

7-010.09 Rental: The following requirements apply to items provided on a rental basis. If the provider is unable to meet these requirements, the Department may select another provider.

7-010.09A Rental/Purchase Decision: Items with a purchase price under \$150 may be purchased rather than rented, unless the physician's estimated duration of need is less than 6 months. Items with a purchase price of \$150 or greater must be rented, unless the physician's estimated duration of need is 12 months or greater.

7-010.09B Rental Option to Purchase: All rentals, except those listed below, must carry an option to purchase the item. THE PROVIDER SHALL CEASE ALL BILLING FOR RENTAL when rental payments reach the provider's purchase price or after 12 monthly rental payments, whichever occurs first. Upon conversion to purchase, the item becomes the property of the client.

When converting a rental item to purchase before 12 months of rental, all rental paid or authorized shall be applied toward the NMAP allowable purchase price. When converting from rental to purchase before 12 months of rental, the provider shall use the appropriate procedure code modifier and list the initial rental date and purchase on or with the claim.

The following items are exempt from the rental/purchase option, remain the property of the provider, and may be rented on a monthly basis -

1. Oxygen delivery equipment; and
2. Ventilators.

The following items are exempt from the rental/purchase option. After 12 monthly rental payments, the item will be paid on a monthly "maintenance" basis and will remain the property of the provider. Providers shall use the appropriate procedure code modifier when billing for monthly "maintenance" -

1. Air fluidized bed units;
2. Apnea monitors;
3. Compressors (air power sources for equipment which is not self-contained or cylinder driven);
4. Electric breast pumps;
5. Low air loss bed units; and
6. Oximeters.

Other items may be exempt from the rental/purchase option if approved by the Medicaid Division.

7-010.09C Rental Payment: Payment for rental includes -

1. All necessary repair and replacement parts; and
2. All accessories and supplies necessary for the effective use of the equipment, unless specifically allowed as outlined in the coverage criteria for the item.

7-010.09D Rental Billing Procedures:

1. Providers shall bill for rental only while the item continues to be medically necessary and appropriately used by the client;
2. Rental items not used by the client for more than a one month period (e.g., during inpatient hospitalization) may not be billed to NMAP. The provider is responsible for determining whether the item continues to be used by the client; and
3. The provider shall bill rental on a monthly basis unless the item is used for less than a one-month period. When billing for monthly rental, the unit of service "1" indicates a one-month rental period. The provider shall use the appropriate procedure code modifier when billing for monthly rental. The beginning rental date for each month shall be the day of the month on which the item was initially provided. A monthly rental period is not necessarily a calendar month or a standard number of days (e.g., 28, 30, 31). Examples of monthly rental periods are -

January 5 - February 4
March 20 - April 19
June 15 - July 14

When rental equipment is needed at any time by the client for less than a one-month rental period, the rental is paid on a daily pro-rated basis. The provider shall use the appropriate procedure code modifier when billing for daily rental. The unit of service must reflect the number of days the item was actually used.

4. When billing for rental items, the provider shall indicate both "from" and "to" dates of service and the initial rental date.

7-010.09E Rental Delivery and Setup: If the client no longer requires rental equipment during the first month rental period and the rental item required delivery and set-up (e.g., oxygen delivery equipment, hospital bed, etc.), the provider may bill for "equipment set-up" in addition to the daily pro-rated rental fee for the days the equipment was actually used. Delivery and set-up charges may not be billed for client instruction on use of equipment or for equipment that is generally covered or customarily provided for a period of less than one month (e.g., home phototherapy services, CPM devices, etc.).

7-010.09F Loss/Damage of Rental Items: The Department is not responsible for lost, stolen, or damaged rental items.

7-010.10 Used Equipment: Used equipment is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator). The provider must assure that used equipment meets the same standard of quality as new equipment and must provide comparable warranty, servicing and return policies available with new equipment.

When billing for used equipment, the provider shall use the appropriate procedure code modifier.

7-010.11 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division.

7-011 Payment Methodology: NMAP pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
 - a. The unit value multiplied by the conversion factor;
 - b. The invoice cost (indicated as "IC" in the fee schedule);
 - c. The maximum allowable dollar amount; or
 - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule). A copy of the purchase invoice showing the provider's actual cost for an item may be requested and used for pricing.

7-011.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

7-011.02 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471 NAC 3-004.

7-012 Billing Requirements: Providers shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

Any item billed to NMAP must actually be dispensed or directly supplied by the provider that bills for the item. This does not preclude a provider from contracting with billing agents.

The provider or the provider's authorized agent shall submit the provider's usual and customary charge for each procedure code listed on the claim. Any discount offered to the public must be reflected in the provider's submitted charge, except discounts for cash payment at the time of sale.

7-012.01 Procedure Codes and Modifiers: The provider shall bill the Department using the appropriate HCPCS procedure codes and modifiers.

HCPCS procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-507).

7-013 Coverage Index

Note: HCPCS procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-507).

<u>Description</u>	<u>Coverage Criteria</u>
AIR CLEANERS/PURIFIERS	Not covered-environmental control equipment; not primarily medical in nature.
AIR CONDITIONERS	Not covered-environmental control equipment; not primarily medical in nature.
AIR FLUIDIZED and LOW AIR LOSS BED UNITS.....	Covered on a rental basis for - <ol style="list-style-type: none">1. A maximum period of 20 weeks for active healing and treatment of stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcers located on the trunk or pelvis, while progressive, consistent wound healing occurs; or2. A maximum period of eight weeks from the date of surgery for post-operative healing of major skin grafts or myocutaneous flaps on the trunk or pelvis. The client must be placed on the bed unit immediately after the surgical procedure. (<u>Note:</u> The supplier does <u>not</u> bill NMAP for services provided while the client is a hospital patient (see 471 NAC 7-006).

Note: NMAP does not cover air fluidized beds for prevention of pressure ulcers or pain control.

Note: Air powered mattress overlays or mattress replacements are not covered.

The following conditions must be met and documented prior to placement of an air fluidized or low air loss bed unit -

1. Comprehensive client assessment and evaluation by the attending physician has occurred;
2. Conservative treatment has been tried without success;
3. Caregiver training on use of the bed by a registered nurse employed by the provider has occurred; and
4. Initial dietary consult has occurred, which includes recommended caloric intake and serum albumin level at or near the time of placement.

The following conditions must be met and documented during use of air fluidized or low air loss bed units -

1. A trained adult caregiver is available to assist the client with activities of daily living, fluid balance, skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments and management and support of the bed;
2. Wound healing must begin within 14 days of placement on the bed unit. If progressive, consistent wound healing ceases during use of the bed, care plan changes and wound healing must be reestablished within 14 days;
3. The client must remain on the bed unit at all times except for a maximum of 1 hour per day and when receiving medical treatment (e.g., physician visits, whirlpool treatment, etc.);
4. On-site client evaluation and wound care consultation by a registered nurse employed by the provider occurs weekly;
5. Changes in the client's status, treatment, diet, etc., is monitored and documented; and
6. A written plan of care must be established within 4 weeks of placement of bed unit. The plan of care must address skin care, pressure reducing devices and protocol, and dietary needs after use of bed unit has been discontinued.

Payment: NMAP rental payment includes -

1. Air fluidized or low air loss bed unit and all accessories and services necessary for proper functioning and effective use of the bed;
2. Weekly on-site client evaluation and wound care consultation by a registered nurse employed by the provider, with 24 hour per day availability; and
3. Complete caregiver training on use of equipment, wound care and prevention.

Provider Requirements: The provider must have an approved "Coordination Plan" for air fluidized and low air loss bed units (see 471 NAC 7-009).

Clients in Nursing Facilities and ICF/MR's: Air fluidized and low air loss bed units are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The provider must have documentation on file that substantiates that all requirements for coverage are met. Form MS-80 "Air Fluidized and Low Air Loss Bed Certification of Medical Necessity" must be completed on a monthly basis by a registered nurse employed by the provider and signed by the ordering physician and kept on file with the provider. (See 471-000-209 for form and completion instructions.)

Prior Authorization: Prior authorization of payment is not required.

APNEA MONITORS Covered on a rental basis for infants (birth through completion of one year of age) that meet one of the following criteria -

1. Infants with one or more apparent life- threatening events (ALTE's) requiring mouth-to-mouth resuscitation or vigorous stimulation. ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually limpness), choking or gagging. In some cases, the observer fears the infant has died;
2. Symptomatic preterm infants;
3. Siblings of one or more SIDS victims; or
4. Infants with certain diseases or conditions, such as central hyperventilation, bronchopulmonary dysplasia, infants with tracheostomies, infants with substance-abusing mothers, or infants with less severe ALTE's.

Criteria for discontinuing apnea monitoring must be based on the infant's clinical condition. A monitor may be discontinued when ALTE infants have had two- three months free of significant alarms or apnea requiring vigorous stimulation or resuscitation. Evaluating the infant's ability to tolerate stress (e.g., immunizations, illness) during this time is advisable.

Pneumocardiograms are covered for diagnostic/ evaluation purposes and when required to determine when the infant may be removed from the monitor. Payment does not include analysis and interpretation. This service must be billed by the physician performing the service.

Note: NMAP does not cover monitors that do not use rechargeable batteries.

The following conditions must be met prior to initiation of home apnea monitoring -

1. History and physical assessment by the infant's attending physician; and
2. Parent/caregiver have successfully completed training on use of the equipment and any other physician recommended training (e.g., infant resuscitation and stimulation).

Payment: NMAP rental payment includes complete parent/caregiver training on use of the equipment and record keeping. NMAP does not make separate payment for remote alarms. When provided, payment for a remote alarm is included in the monitor rental payment.

Clients in Nursing Facilities and ICF/MR's: Apnea monitors and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Provider Requirements: The provider must have an approved "Coordination Plan" for apnea monitoring services (see 471 NAC 7-009).

Supplies/Accessories: Apnea monitor supplies are covered for use with rented and client-owned apnea monitors. For rented apnea monitors, the apnea monitor supplies must be billed on the same claim as the apnea monitor rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The provider must have documentation on file that substantiates that all conditions for coverage are met. Apnea monitor rental exceeding two months requires a physician's narrative report of client progress to be kept on file with the provider. A new progress report is required every two months. The report must include -

1. The number of apnea episodes during the previous two-month period of use;
2. Tests and results of tests performed during the previous two-month period of use;

3. Estimated additional length of time the monitor will be needed; and
4. Any additional pertinent information the physician may wish to provide.

Prior Authorization: Prior authorization of payment is not required.

BATH and TOILET AIDS..... The following bath and toilet aids are covered for clients with severe conditions which justify use of the item: bath/toilet rails, raised toilet seats, tub stools and benches, transfer tub benches and attachments, and bath support chairs.

Bathtub patient lifts and rehabilitation shower chairs are covered for clients with severe conditions who, without use of the equipment, would be unable to bathe or shower. The client must be unable to use a stationary tub stool or bench, rails and/or similar equipment.

Note: Bed baths and shower attachments (e.g., hand-held shower attachments, faucet adapters, etc.) are not covered.

Clients in Nursing Facilities and ICF/MR's: Bath and toilet aids are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

BED BATHS Not covered-hygienic equipment; not primarily medical in nature.

BED LIFTERS Not covered-not primarily medical in nature.

BED SIDE RAILS..... Covered for clients who are at risk for injury due to one of the following conditions -

1. Disorientation;
2. Vertigo; or
3. A neurological disorder resulting in convulsive seizures.

Bed side rails are also covered when an integral part of, or an accessory to, a hospital bed.

Clients in Nursing Facilities and ICF/MR's: Bed side rails are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

(See also HOSPITAL BED ACCESSORIES.)

BED TABLES, ANY TYPE..... Not covered-convenience item; not primarily medical in nature.

BED WEDGES Covered for clients that require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration. Standard bed pillows must have been tried and failed.

Clients in Nursing Facilities and ICF/MR's: Bed wedges are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

BEDBOARDS Not covered-not primarily medical in nature.

BEDPANS and URINALS Covered for clients who are bed-confined.

Clients in Nursing Facilities and ICF/MR's: Bedpans and urinals are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

BEDS, HOSPITAL..... See HOSPITAL BEDS.

BEDS, LOUNGE (MANUAL OR POWER)	Not covered-not a hospital bed; comfort or convenience item; not primarily medical in nature.
BEDS, OSCILLATING	Not covered-institutional equipment; inappropriate for home use.
BIOFEEDBACK DEVICES.....	See ELECTROMYOGRAPHY (EMG) BIOFEEDBACK DEVICES.
BLOOD GLUCOSE MONITORS	<p>Covered for clients that meet all of the following conditions -</p> <ol style="list-style-type: none">1. The client is diabetic (<u>includes non-insulin treated diabetes and gestational diabetes</u>);2. The client's physician states that the client is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the client may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the client to assure that the intended effect is achieved. This is permissible if this information is properly documented by the client's physician; and3. The device is designed for home rather than clinical use. <p>Blood glucose monitors with such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable clients with visual impairments to use the equipment without assistance are covered when the following conditions are met -</p> <ol style="list-style-type: none">1. The client and device meet the three conditions listed above for coverage of standard blood glucose monitors; and2. The client's physician certifies that the client has a visual impairment severe enough to require use of this special monitoring system.

Clients in Nursing Facilities and ICF/MR's: Blood glucose monitors and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Supplies necessary for effective use and proper functioning of a blood glucose monitor are covered for use with rented and client-owned monitors for clients whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is not required.

BLOOD PRESSURE

MONITORS

Covered for clients with hypertension whose condition must be self-monitored at home. An electronic blood pressure monitor is covered only if the client is unable to use a standard cuff and stethoscope due to conditions such as poor eyesight or hearing, arthritis, or other physical disability.

Note: Blood pressure monitors required for renal dialysis are payable ONLY to approved renal dialysis facilities. (See DIALYSIS EQUIPMENT AND SUPPLIES.)

Clients in Nursing Facilities and ICF/MR's: Blood pressure monitors and accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase and rental of a blood pressure monitor includes all accessories necessary for proper functioning and effective use of the monitor. Accessories are payable only as replacement for use with client-owned monitors for clients whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The documentation must specify the cuff size, that the physician will be monitoring its use in connection with the client's continuing course of treatment, and that the client or caregiver will be instructed in use of the equipment by the physician, physician's office staff or other qualified health professional.

Prior Authorization: Prior authorization of payment is not required.

BONE GROWTH

STIMULATORS See OSTEOGENESIS STIMULATORS.

BRAILLE TEACHING TEXTS Not covered-education equipment; not primarily medical in nature.

BREAST PROSTHESES

(EXTERNAL) and SUPPLIES Covered for clients who have had a mastectomy.

Clients in Nursing Facilities and ICF/MR's: Breast prostheses and related supplies are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

BREAST PUMPS Covered for clients who are breast feeding. Electric breast pumps are covered only on a rental basis.

Clients in Nursing Facilities and ICF/MR's: Breast pumps and related accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: During rental of a breast pump, supplies and accessories necessary for proper functioning and effective use of the pump are included in the rental allowance. For the purchase of a pump, the allowance includes supplies and accessories needed for one month. Accessories and supplies are payable only as a replacement for use with client-owned pumps for clients whose condition meets the criteria for coverage of the pump.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

CANES and CRUTCHES Covered for clients with conditions that impair ambulation.

Note: A white cane for use by a blind person is considered an identifying and self-help device rather than an item which makes a meaningful contribution to the treatment of an illness or injury and is therefore not covered.

Clients in Nursing Facilities and ICF/MR's: Canes, crutches and related accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase and rental of canes and crutches includes all accessories necessary for proper functioning and effective use of the item. Accessories such as tips, handgrips, etc., are payable only as replacement for use with client-owned canes or crutches for clients whose condition meets the criteria for coverage of the item.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

CAR SEATS..... Positioning seats approved for use in vehicles are covered for clients age 20 and younger with physical disabilities when required for positioning during transportation when standard seat belts or infant car seats are not appropriate.

Clients in Nursing Facilities and ICF/MR's: Car seats are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is required for rental and purchase of car seats. See 471 NAC 7-008 for prior authorization requirements.

CARAFES Not covered-convenience item; not primarily medical in nature.

COMMODOES Covered for clients who are confined to bed or room or confined to home in which there are no bathroom facilities on that floor or bathroom facilities are inaccessible.

A commode chair with detachable arms is covered only if medically necessary, such as for obesity or paraplegia.

Clients in Nursing Facilities and ICF/MR's: Commodes and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase and rental of a commode includes all accessories necessary for proper functioning and effective use of the commode. Accessories such as a commode pail or pan are payable only as replacement for use with client-owned commodes whose condition meets the criteria for coverage of the monitor.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

COMMUNICATION DEVICES,
AUGMENTATIVE

Covered for clients who are unable to use natural oral speech as a primary means of communication. The specific device requested must be appropriate for use by the client and the client must demonstrate the abilities or potential abilities to use the device selected. Client/family/environment must support the use of the device.

Coverage is limited to portable devices needed to supplement, aid or serve as an alternative to natural speech for clients with severe expressive communication disorders. Non-portable devices may be covered only if required for visual enhancement or physical access needs that cannot be accommodated by a portable device.

An evaluation of the client's communication needs by a qualified professional speech pathologist is required. A background and experience in augmentative communication is recommended.

A qualified professional speech pathologist must -

1. Have been granted a certificate of clinical competence from the American Speech and Hearing Association or have completed the equivalent educational requirements and work experience needed for the certificate or have completed the academic program and is acquiring supervised work experience to qualify for the certificate; and
2. If practicing in Nebraska, be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure or be certified by the Nebraska Department of Education; or
3. If practicing outside Nebraska, meet that state's requirements for participation in the Medicaid Program.

The evaluation must address the client's medical diagnosis, speech-language diagnosis, physical status, communication abilities, vision and hearing acuity, cognitive, neuromotor, language and other skills or potential required for use of the specific device selected. The specific device recommended, along with all accessories required for use of the device must be identified and the selection justified.

A trial period with the device selected may be required. A maximum of three months rental may be approved for rental of devices not subsequently purchased. (See 471 NAC 7-010.08 for rental requirements.)

When an augmentative communication device is no longer needed or when a replacement device is requested, it is strongly encouraged that augmentative communication devices purchased with Medicaid funds be donated to a regional or facility-based "equipment pool".

Clients in Nursing Facilities and ICF/MR's: Communication devices and related accessories are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-78, "Augmentative Communication Device Selection Report", must be completed and signed by the evaluating speech-language pathologist and the ordering physician. Form MS-78 is submitted with the request for prior authorization.

Prior Authorization: Prior authorization of payment is required for rental and purchase of augmentative communication devices and accessories. See 471 NAC 7-008 for prior authorization requirements.

COMPRESSORS..... See NEBULIZERS and COMPRESSORS.

CONTINUOUS PASSIVE
MOTION (CPM) DEVICES

Covered for clients who have received a total knee replacement. To qualify for coverage, use of the device must commence within two days following surgery. Coverage is limited to that portion of the three-week period following surgery during which the device is used in the client's home.

Clients in Nursing Facilities and ICF/MR's: CPM devices and accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Accessories/Supplies: Payment for rental of CPM devices includes all accessories necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

CONTINUOUS POSITIVE
AIRWAY PRESSURE
SYSTEMS (CPAP).....

Covered for clients with moderate or severe obstructive sleep apnea for whom surgery is a likely alternative to CPAP.

Intermittent assist devices with CPAP are covered for clients that after trial use with CPAP cannot tolerate use of CPAP without intermittent assist devices.

Humidifiers for use with CPAP are covered for clients that require supplemental humidification with CPAP.

Clients in Nursing Facilities and ICF/MR's: CPAP devices and accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of CPAP devices are covered for use with rented and client-owned devices for clients whose condition meets the criteria for coverage of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is not required.

CRADLES, ANY TYPE..... Not covered-not primarily medical in nature.

CRUTCHES..... See CANES and CRUTCHES.

DEHUMIDIFIERS, ROOM OR
CENTRAL HEATING SYSTEM
TYPES Not covered-environmental control equipment; not primarily medical in nature.

DIALYSIS EQUIPMENT and
SUPPLIES NMAP reimburses for dialysis systems, related supplies and equipment only to approved renal dialysis facilities under the Medicare Method I (composite rate) payment methodology. Payment can not be made to suppliers, pharmacies or home health agencies for dialysis systems, related supplies and equipment.

DIATHERMY MACHINES,
STANDARD and PULSED
WAVE TYPES Not covered-inappropriate for home use.

DRESSINGS..... Covered for clients that require treatment of a wound or surgical incision.

Note: Skin/wound cleaners are not covered.

Clients in Nursing Facilities and ICF/MR's: Dressings are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

ELECTRICAL NERVE
STIMULATORS See NEUROMUSCULAR ELECTRICAL STIMULATORS;
TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS.

ELECTROMYOGRAPHY
(EMG) BIOFEEDBACK
DEVICES.....

Covered for muscle re-education of specific muscle groups or for treating pathological muscle spasm, or weakness, when more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for psychosomatic conditions, or for psychiatric conditions.

Clients in Nursing Facilities and ICF/MR's: EMG biofeedback devices are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase and rental of a EMG biofeedback device includes all accessories necessary for proper functioning and effective use of the device. Accessories are payable only as replacement for use with client-owned devices for clients whose condition meets the criteria for coverage of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

ELEVATORS..... Not covered-convenience item; not primarily medical in nature.

EMESIS BASINS Not covered-convenience item; not primarily medical in nature.

ENTERAL NUTRITION..... Covered for clients with normal gastrointestinal (G.I.) absorptive capacity who, due to permanent or temporary nonfunction or disease of the structures that normally permit food to reach the small bowel, requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the client's overall health status. Note: Permanent impairment is not required for coverage.

Coverage includes enteral nutrients, infusion pumps, feeding supply kits, and nasogastric/gastrostomy/jejunostomy tubes. Enteral feeding supply kits include all the necessary supplies (excluding the tubing) for the enteral patient using the syringe, gravity, or pump method of nutrient administration.

No more than one month supply of enteral nutrients, equipment or supplies may be provided in advance.

If a pump is ordered, there must be documentation to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload).

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Note: For clients eligible for the Supplemental Feeding and Nutrition Program for Women, Infants and Children (WIC), enteral nutrients are covered if the product is not covered by WIC or if the quantity required exceeds the maximum quantity provided by WIC.

Clients in Nursing Facilities and ICF/MR's: Enteral nutrients, equipment and supplies are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is not required.

(See also NUTRITIONAL SUPPLEMENTS; PARENTERAL NUTRITION.)

ENURESIS ALARMS..... Not covered-not primarily medical in nature.

ENVIRONMENTAL CONTROL
EQUIPMENT Not covered-not primarily medical in nature.

ESOPHAGEAL DILATORS Not covered-physician instrument.

EXERCISE EQUIPMENT Not covered-not primarily medical in nature.
(includes exercise bicycles,
Moore wheel, treadmills,
weights)

EYE PROSTHESES..... Covered for clients with absence or shrinkage of an eye due to birth defect, trauma or surgical removal.

Clients in Nursing Facilities and ICF/MR's: Eye prostheses are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

FAMILY PLANNING

SUPPLIES Covered when required to prevent or delay pregnancy.

Clients in Nursing Facilities and ICF/MR's: Family planning supplies are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

FOOT ORTHOSES

(orthopedic shoes, shoe modifications, transfers).....

Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet. Coverage of orthopedic shoes is limited to one pair at the time of purchase. Except when documentation indicates excessive wear or size change necessary due to growth, only one pair of orthopedic shoes is covered in a one year period.

Clients in Nursing Facilities and ICF/MR's: Foot orthoses are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

HEARING AID BATTERIES Covered for clients that use hearing aids.

Note: For policy regarding NMAP coverage of hearing aids, see 471 NAC 8-000.

Clients in Nursing Facilities and ICF/MR's: Hearing aid batteries are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

HEAT/COLD APPLICATION
DEVICES.....

Covered for clients with medical conditions for which the application of heat or cold is therapeutic.

Clients in Nursing Facilities and ICF/MR's: Heat/cold appliance devices are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

(See also PARAFFIN BATH UNITS.)

HEATING and COOLING
PLANTS/EQUIPMENT

Not covered-environmental control equipment; not primarily medical in nature.

HOSPITAL BEDS.....

A fixed height hospital bed is one with manual head and leg elevation adjustments, but no height adjustments. A fixed height hospital bed is covered for clients whose condition meets one of the following criteria-

1. Requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month. Elevation of the head/upper body less than 30 degrees does not usually require use of a hospital bed;

2. Requires, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed;
3. Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration. Pillows or wedges must have been tried and failed; or
4. Requires traction equipment which can only be attached to a hospital bed.

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

A variable height hospital bed is covered if the client's condition meets the criteria for coverage of a fixed height hospital bed and the client also requires a bed height different from that provided by fixed height hospital bed in order to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed is one with manual height adjustment and with electric head and leg elevation adjustments. A semi-electric hospital bed is covered if the client's condition meets the criteria for coverage of a fixed height hospital bed and the client also requires frequent changes in body position and/or has an immediate need for a change in body position.

Note: A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments. An electric bed height adjustment feature is not covered; it is a convenience feature. If the documentation supports a lower level bed, payment is based on the allowable for the least costly alternative.

Clients in Nursing Facilities and ICF/MR's: Hospital beds are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: An innerspring or foam rubber mattress is covered when an integral part of, an accessory to or as a replacement for a medically necessary hospital bed owned by the client.

Side rails are covered when an integral part of, or an accessory to, a medically necessary hospital bed if the client's condition requires bed side rails. (See also BED SIDE RAILS.)

A trapeze bar is covered for clients who need the device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

A bed cradle is covered for clients with acute gouty arthritis or burns for whom it is necessary to prevent contact with the bed coverings.

Note: An overbed table is not covered since it is a convenience item and not primarily medical in nature.

Note: A bed board is not covered since it is not primarily medical in nature.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is required only for electric hospital beds.

HUMIDIFIERS (ROOM OR
CENTRAL HEATING TYPE).....

Not covered-environmental control equipment; not primarily medical in nature. (See also VAPORIZERS.)

IMPOTENCE TREATMENT

DEVICES..... Covered for clients with organic impotence and without conditions that contraindicate use of the device.

Clients in Nursing Facilities and ICF/MR's: Impotence treatment devices and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase of the device includes all accessories necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

INCONTINENCE APPLIANCES

and CARE SUPPLIES..... Covered for clients without control over bladder or bowel function. Incontinence diapers/briefs and liners are not covered for clients under age 3.

Note: Skin cleansers are not covered.

Clients in Nursing Facilities and ICF/MR's: Incontinence appliances and care supplies are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

INFUSION PUMPS,

EXTERNAL..... Covered for clients with conditions which require administration of parenteral medication when reasonable and necessary, and when an infusion pump is necessary to safely administer the medication.

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Insulin Infusion pumps, Continuous Subcutaneous (CSII): Purchase is covered on a prior authorization basis based on medical necessity. The provider shall obtain written documentation from the prescribing physician which includes at minimum, the following:

1. Diabetes Team Evaluation Summary: Letter from the prescribing physician who is part of a diabetes team; (the team must include at minimum a physician with expertise in diabetes and a diabetic health educator) must address at minimum:
 - a. Diagnosis;
 - b. Complications/Compounding issues;
 - c. Failure of adequate blood glucose control in spite of demonstrated compliance with multiple daily injections;
 - d. Hgb A_{1c} levels; and
 - e. Patient's ability and motivation to use the pump.
2. Treatment plan: A comprehensive plan of care for the client utilizing the CSII which includes:
 - a. Inpatient initiation of CSII or rationale for outpatient initiation with all policies and procedures involved;
 - b. Client/family diabetes education plan; and
 - c. Monitoring plan post-initiation of CSII.

Clients in Nursing Facilities and ICF/MR's: Infusion pumps and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Supplies necessary for effective use and proper functioning of an external infusion pumps are covered for use with rented and client-owned pumps for clients whose condition meets the criteria for coverage of the pump.

Note: For billing of medications administered with external infusion pumps, see 471 NAC 16-000, Pharmacy Services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is required only for Continuous Subcutaneous Insulin Infusion Pumps. See 471 NAC 7-007 and 7-008 for documentation of medical necessity and prior authorization requirements.

(See also ENTERAL NUTRITION; PARENTERAL NUTRITION.)

INJECTORS (hypodermic jet
pressure powered devices for
injection of insulin) Not covered-effectiveness not adequately demonstrated.

INTERMITTENT POSITIVE
PRESSURE BREATHING
(IPPB) MACHINES Covered for clients whose ability to breathe is severely impaired.

Clients in Nursing Facilities and ICF/MR's: IPPB machines and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase and rental of an IPPB machine includes all accessories necessary for proper functioning and effective use of the machine. Accessories are payable only as replacement for use with client-owned devices for clients whose condition meets the criteria for coverage of the machine.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

LIFTS, PATIENT Covered for clients when transfer between bed and a chair, wheelchair or commode requires the assistance of more than one person or without the use of a lift, the client would be bed confined.

Clients in Nursing Facilities and ICF/MR's: Patient lifts are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Documentation must verify the client can use the lift and has had a successful trial, if first time user.

Prior Authorization: Prior authorization of payment is not required.

(See also BATH and TOILET AIDS; SEAT LIFT CHAIRS.)

LIFTS, WHEELCHAIR/
EQUIPMENT Not covered-convenience item; not primarily medical in nature.

LOW AIR LOSS BED UNITS..... See AIR FLUIDIZED and LOW AIR LOSS BED UNITS.

LOWER and UPPER LIMB
ORTHOSES Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Clients in Nursing Facilities and ICF/MR's: Lower and upper limb orthoses are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

LOWER and UPPER LIMB

PROSTHESES Covered when required to replace a missing body part.

Note: Myoelectric and electronically switch controlled prosthetic devices are not covered.

Clients in Nursing Facilities and ICF/MR's: Lower and upper limb prostheses are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

LYMPHEDEMA PUMPS See PNEUMATIC COMPRESSORS.

MASSAGE DEVICES Not covered-comfort item; not primarily medical in nature.

MATTRESS/PILLOW
COVERS Not covered-not primarily medical in nature.

MEDICAL IDENTIFICATION
ITEMS Not covered-do not serve a diagnostic or therapeutic purpose.

MEDICAL/SURGICAL
SUPPLIES Covered for clients that require home treatment of a specific medical condition, protection or support of a wound, surgical incision or diseased or injured body part.

Note: Skin/wound cleansers and "ready to use" disinfectant cleaning solution are not covered.

Clients in Nursing Facilities and ICF/MR's: Medical/ surgical supplies are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

(See also DRESSINGS; INCONTINENCE APPLIANCES and CARE SUPPLIES; OSTOMY SUPPLIES; TRACHEOSTOMY CARE SUPPLIES.)

NEBULIZERS and

COMPRESSORS.....

Covered if the client's ability to breathe is severely impaired, to administer aerosol therapy when use of a metered dose inhaler is not adequate or appropriate, or when required for use in connection with durable medical equipment for purposes of moisturizing oxygen.

Heated nebulizers are covered for clients with tracheostomies that require heated oxygen.

Portable compressors with internal battery features require specific documentation from the physician justifying the medical necessity of the portable feature.

Ultrasonic nebulizers are covered only when other means of nebulization is documented by the physician to be ineffective.

Note: For nebulizers and humidifiers for use with a flow meter or regulator, see OXYGEN and OXYGEN EQUIPMENT.

Clients in Nursing Facilities and ICF/MR's: Nebulizers, compressors and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of a nebulizer or compressor are covered for use with rented and client-owned equipment for clients whose condition meets the criteria for coverage of the compressor. Note: Distilled water is not covered. For billing of medications for inhalation therapy, see 471 NAC 16-000, Pharmacy Services.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is required only for rental and purchase ultrasonic nebulizers. See 471 NAC 7-008 for prior authorization requirements.

NEUROMUSCULAR
ELECTRICAL STIMULATORS
(NMES).....

Covered for treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse are causing atrophy. Some examples would be castings or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins). Note: Neuromuscular electric stimulators are not covered for treatment of scoliosis.

A conductive garment for use with a NMES unit may be covered when medical necessity is sufficiently substantiated.

Clients in Nursing Facilities and ICF/MR's: NMES units and related accessories/supplies are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: NMES supplies are covered for use with rented and client-owned NMES units for clients whose condition meets the criteria for coverage of the unit. For rented NMES units, the lead wires and supplies must be billed on the same claim as the NMES rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

NUTRITIONAL

SUPPLEMENTS Covered for clients who require nutritional supplementation to maintain weight and strength commensurate with the client's general condition.

Note: Infant formula for oral nutritional supplements is covered for clients age 20 and younger only if medically necessary for special dietary needs (e.g., soy based, low iron, premature, etc.)

Note: For clients eligible for the Supplemental Feeding and Nutrition Program for Women, Infants and Children (WIC), nutritional supplements are covered if the product is not covered by WIC or if the quantity requirement exceeds the maximum quantity provided by WIC.

Clients in Nursing Facilities and ICF/MR's: Nutritional supplements are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

(See also ENTERAL NUTRITION; PARENTERAL NUTRITION.)

OCULAR PROSTHESES See EYE PROSTHESES.

ORTHOPEDIC SHOES See FOOT ORTHOSES.

ORTHOSES See FOOT ORTHOSES; UPPER and LOWER LIMB ORTHOSES.

OSTEOGENIC STIMULATORS

(NONINVASIVE) Covered for client's with one of the following indications -

1. Nonunion of long bone fractures;
2. Failed fusion; and
3. Congenital pseudoarthrosis.

Nonunion of long bone fractures is considered to exist only after six or more months.

A failed fusion is considered to exist only after 6 months or more have elapsed without healing of the fusion.

Clients in Nursing Facilities and ICF/MR's: Osteogenic stimulators and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for osteogenic stimulators includes all accessories and supplies necessary for proper functioning and effective use of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is not required.

OSTOMY SUPPLIES Covered for clients with an ostomy.

Skin moisturizers, protectants and sealants are covered only if medically necessary for clients with ostomies.

Note: Skin cleansers are not covered.

Clients in Nursing Facilities and ICF/MR's: Ostomy supplies are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

OVERBED TABLES..... Not covered-convenience item; not primarily medical in nature.

OXIMETERS, EAR/PULSE..... Covered on a rental basis for clients who require a minimum of daily monitoring of arterial blood oxygen saturation levels for evaluation and regulation of home oxygen therapy. Coverage for other indications will be determined on a case-by-case basis.

Note: In-home overnight (12 hour or similar) oximetry trend studies and other single test ("one time") oximetry testing is not covered.

Clients in Nursing Facilities and ICF/MR's: Ear/pulse oximeters and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: During rental of an oximeter, supplies and accessories necessary for proper functioning and effective use of the device are included in the rental allowance.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The documentation must specify -

1. The client's medical condition which substantiates the need for in-home use of oximeter;
2. The estimated length of need for monitoring; and
3. The frequency of monitoring required (e.g., continuous, daily, etc.).

A monthly updated certification of medical necessity is required when the oximeter is required for evaluation and regulation of home oxygen therapy.

Prior Authorization: Prior authorization of payment is required for rental of oximeters. See 471 NAC 7-008 for prior authorization requirements.

OXYGEN and OXYGEN
EQUIPMENT

Covered for clients with significant hypoxemia in the chronic stable state provided the following conditions are met:

1. The attending physician has determined that the client suffers severe lung disease or hypoxia- related symptoms that might be expected to improve with oxygen therapy;
2. The client's blood gas levels indicate the need for oxygen therapy; and
3. The client has appropriately tried other alternative treatment measures without complete success.

Oxygen therapy is covered for clients with significant hypoxemia evidenced by any of the following:

1. An arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken -
 - a. at rest;
 - b. during sleep for a client who demonstrates an arterial PO₂ at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, while awake, or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO₂ more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent) associated with symptoms or signs reasonable attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for nocturnal use of oxygen; or
 - c. during exercise for a client who demonstrates an arterial PO₂ at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air; or
2. An arterial PO₂ of 56 to 59 mm Hg or an arterial blood oxygen saturation of 89 percent if any of the following are documented -
 - a. Dependent edema suggesting congestive heart failure;
 - b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, "P" pulmonale of EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or
 - c. Erythrocythemia with a hematocrit greater than 56 percent.

Oxygen therapy is not covered for -

1. Angina pectoris in the absence of hypoxemia;
2. Dyspnea without cor pulmonale or evidence of hypoxemia;
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities; and
4. Terminal illness that does not affect the lungs.

Portable oxygen systems alone or to complement a stationary oxygen system may be covered if the client is mobile within the residence.

Respiratory therapists' services are not covered. The durable medical equipment benefit provides for coverage of oxygen and oxygen equipment, but does not include a professional component in the delivery of such services.

Note: The following items are not covered since they are precautionary and not therapeutic in nature -

1. Spare tanks of oxygen;
2. Emergency oxygen inhalators; and
3. Preset portable oxygen delivery unit (where flow rate is not adjustable).

Note: Piped-in oxygen delivery is not considered an acceptable delivery mode for reimbursement as durable medical equipment.

Clients in Nursing Facilities and ICF/MR's: Oxygen and oxygen equipment is covered for clients residing in nursing facilities and ICF/MR's if the client's prescribed need for oxygen meets the criteria for coverage outlined above and the client's prescribed need for oxygen meets the minimum liters per minute and hours per day outlined in 471 NAC 7-005, #7.

Payment: Payment for oxygen therapy includes the oxygen contents, the system for furnishing it, the vessels that store it, and the tubing and administration sets that allow the safe delivery of oxygen.

When a both stationary and portable system is being rented, the allowable for all contents is included in the allowable for the stationary system. Stationary contents are payable only when the client owns the gaseous or liquid stationary system. Portable contents are payable only when the client uses a portable system only (either rented or owned).

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of the Medicare CMN form is required. Documentation must include the results of a blood gas study that has been ordered and evaluated by the attending physician. This will usually be in the form of a measurement of the partial pressure of oxygen (PO₂) in the arterial blood. A measurement of pulse arterial oxygen saturation may also be acceptable when ordered and evaluated by the attending physician and performed under his/her supervision or when performed by a qualified provider or supplier of laboratory services. Note: A DME supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines. When a client's initial certification for oxygen is approved based on an arterial PO₂ of 56 mm Hg or greater or an oxygen saturation of 89% or greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity.

Supplies/Accessories: Oxygen supplies/accessories (e.g., tubing, administration sets, etc.), are payable only as replacement for use with client owned delivery systems for clients whose condition meets the criteria for coverage of oxygen therapy.

Prior Authorization: Prior authorization of payment is not required.

Billing Requirements: When billing for oxygen therapy, the provider shall use the appropriate unit of service as described in the procedure code. Units of service should be rounded to the nearest unit of the procedure code description.

PACEMAKER MONITORS,
SELF CONTAINED

Covered for clients with cardiac pacemakers.

Clients in Nursing Facilities and ICF/MR's: Pacemaker monitors are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

PARAFFIN BATH UNITS,

PORTABLE Covered for clients with conditions that are expected to be relieved by long term use of this modality and who have undergone a successful trial period of paraffin therapy.

Clients in Nursing Facilities and ICF/MR's: Paraffin bath units and paraffin are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Paraffin is covered for use with rented and client-owned paraffin bath units for clients whose condition meets the criteria for coverage of the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

PARALLEL BARS..... Not covered-support exercise equipment; primarily for institutional use; in the home setting, other devices (e.g., walkers) available to meet client's needs.

PARENTERAL NUTRITION..... Covered for clients with severe permanent or temporary disease of the gastrointestinal tract which prevents absorption of sufficient nutrients to maintain weight and strength commensurate with the client's overall health status.

Coverage includes parenteral nutrition infusion pumps, supply and administration kits, and parenteral nutrients. Parenteral supply and administration kits include all the components necessary to administer therapy.

No more than one month supply of parenteral nutrients, equipment or supplies may be provided in advance.

Note: Disposable drug delivery systems (elastomer infusion pumps) and infusion controller devices are not covered.

Note: For clients eligible for the Supplement Feeding and Nutrition Program for Women, Infants and Children (WIC), parenteral nutrients are covered if the product is not covered by WIC or if the quantity required exceeds the maximum quantity provided by WIC.

Clients in Nursing Facilities and ICF/MR's: Parenteral nutrition solutions and additives are covered for clients residing in nursing facilities and ICF/MR's. Related supplies and equipment are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

PEAK FLOW METERS Covered for clients with chronic asthma.

Clients in Nursing Facilities and ICF/MR's: Peak flow meters are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

PERCUSSORS Covered for mobilizing respiratory tract secretions in clients with cystic fibrosis, chronic obstructive lung disease, chronic bronchitis, or emphysema, when the client or operator of powered percussor has received appropriate training by a physician or therapist and no one competent to administer manual therapy is available.

Clients in Nursing Facilities and ICF/MR's: Percussors are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

PHOTOTHERAPY SERVICES Covered on a rental basis for infants that meet the following criteria -

1. Neonatal hyperbilirubinemia is the infant's sole clinical problem;
2. The infant is greater than or equal to 37 weeks gestational age and birth weight greater than 2,270 gm (5 lbs);
3. The infant is greater than 48 hours of age;
4. Bilirubin level at initiation of phototherapy (greater than 48 hours of age) is 14-18 mgs per deciliter; and
5. Direct bilirubin level is less than 2 mgs per deciliter.

Home phototherapy is not covered if the bilirubin level is less than 12 mgs. at 72 hours of age or older.

The following conditions must be met prior to initiation of home phototherapy -

1. History and physical assessment by the infant's attending physician has occurred. If home phototherapy begins immediately upon discharge from the hospital, the newborn discharge exam will suffice;
2. Required laboratory studies have been performed, including, CBC, blood type on mother and infant, direct Coombs, direct and indirect bilirubin;
3. The physician certifies that the parent/caregiver is capable of administering home phototherapy;
4. Parent/caregiver have successfully completed training on use of the equipment; and
5. Equipment must be delivered and set up within 4 hours of discharge from the hospital or notification of provider, whichever is more appropriate. There must be a 24-hour per day repair and/or replacement service available.

At a minimum, one bilirubin level must be obtained daily while the infant is receiving home phototherapy.

Payment: NMAP daily rental payment includes -

1. Phototherapy unit and all supplies, accessories, and services necessary for proper functioning and effective use of the therapy;

2. A minimum of one daily visit to the home by a licensed and/or certified "health care professional" as identified by the supplier in the "Coordination Plan" (see 471 NAC 7-006). The daily visits must include -
 - a. A brief home assessment; and
 - b. Collection and delivery of blood specimens for bilirubin testing when ordered by the physician to be collected in the home. The physician must be informed by the provider that this service is available.An outside agency or laboratory with whom the provider contracts for collection and delivery of blood specimens may not bill NMAP directly since payment is included in the daily rental payment. Daily home visits must occur for home assessment even if the blood collection is done outside the home.
3. Complete caregiver training on use of equipment and completion of necessary records.

Provider Requirements: The provider must have an approved "Coordination Plan" for home phototherapy (see 471 NAC 7-006).

Clients in Nursing Facilities and ICF/MR's: Phototherapy services are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. A physician's narrative report outlining the client's progress and the circumstances necessitating extended therapy must be submitted with the claim when billing for home phototherapy exceeding three days.

Prior Authorization: Prior authorization of payment is not required.

Billing Requirements: The provider shall bill for home phototherapy daily rental on a single claim and indicate the total number of rental days as the units of service.

PILLOWS Not covered-convenience item; not primarily medical in nature.
(See also BED WEDGES; TRACTION EQUIPMENT.)

PNEUMATIC COMPRESSORS

and APPLIANCES..... Covered for clients with intractable edema of the extremities.

Rental of a pneumatic appliance is not covered because the item is intended for single-person use.

Clients in Nursing Facilities and ICF/MR's: Pneumatic compressors and appliances are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is not required.

POSTURAL DRAINAGE

BOARDS..... Covered for clients with chronic pulmonary conditions.

Clients in Nursing Facilities and ICF/MR's: Postural drainage boards are not covered for clients residing in nursing facilities or ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

PRESSURE REDUCING

SUPPORT SURFACES..... Pressure reducing mattress pads/overlays are covered when the client meets one of the following criteria -

1. Completely immobile (i.e., the client cannot make changes in body position without assistance);
2. Limited mobility (i.e., the client can not independently make changes in body position significant enough to alleviate pressure); or
3. Any stage pressure ulcer on the trunk or pelvis.

If the client meets criteria 2 or 3 above, the client must also meet at least one of the following criteria -

- a. Impaired nutritional status;
- b. Fecal or urinary incontinence;
- c. Altered sensory perception; or
- d. Compromised circulatory status.

Pressure reducing mattress replacements are covered when the client meets the coverage criteria for a pressure reducing mattress pad/overlay and -

1. Anticipated length of need is at least one year; or
2. "Bottoming out" is anticipated on a comparable pad/overlay. "Bottoming out" is the finding that the client's body will be in contact with a flat outstretched hand (palm up) that is placed underneath the support surface in various body positions.

Note: Powered mattress pads/overlays and mattress replacements, except alternating pressure pads, are not covered.

The client must also have a care plan established by the physician or other licensed healthcare practitioner directly involved in the client's care which should include the following:

1. Education of the client and caregiver on the prevention and/or management of pressure ulcers;
2. Regular assessment by a licensed health healthcare practitioner;
3. Appropriate turning and positioning;
4. Appropriate wound care (for stage II, III, or IV ulcer);
5. Moisture/incontinence control, if needed; and
6. Nutritional assessment and intervention consistent with the overall plan of care if there is impaired nutritional status.

Adherence to the care plan/treatment is not to be construed as elements for coverage criteria.

Pressure reducing cushions are covered for clients with or highly susceptible to pressure ulcers and whose physician will be supervising its use in connection with his/her course of treatment.

Clients in Nursing Facilities and ICF/MR's: Coverage of pressure reducing support surfaces for clients residing in nursing facilities and ICF/MR's is limited to certain cushions for use in client-owned wheelchairs.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. The client's physician must have prescribed the item for treatment must specify in the prescription that s/he will be supervising its use in connection with the client's course of treatment. Use of Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is required for rental and purchase of pressure reducing cushions for clients residing in nursing facilities and ICF/MR's. See 471 NAC 7-008 for prior authorization requirements.

(See also AIR FLUIDIZED and LOW AIR LOSS BED UNITS.)

PROSTHESES	See BREAST PROSTHESES; EYE PROSTHESES; UPPER and LOWER LIMB PROSTHESES.
PULSE TACHOMETERS	Not covered-not reasonable or necessary for monitoring pulse of client with or without a cardiac pacemaker.
REPAIR	See 471 NAC 7-010.06 for repair policy.
RESTRAINTS, ANY TYPE (including body, chest, wrist, ankle, or for use in cars)	Not covered-not primarily medical in nature.
SAUNA BATHS	Not covered-not primarily medical in nature.
SEAT LIFTS.....	Covered if all the following criteria are met - <ol style="list-style-type: none">1. The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease;2. The seat lift chair must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the client's condition;3. The client must be completely incapable of standing up from a regular armchair or any chair in their home; and4. Once standing, the client must have the ability to ambulate.

Coverage is limited to those types which operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to standing position.

Payment: Payment for seat lift chairs which incorporates a recliner feature along with the seat lift is limited to the amount payable for a seat lift without this feature.

Clients in Nursing Facilities and ICF/MR's: Seat lifts are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is required for seat lifts. See 471 NAC 7-008 for prior authorization requirements.

Medicare/Medicaid Clients: For clients eligible for both Medicare and Medicaid, the seat portion of the seat lift chair will be covered by NMAP if the seat lift mechanism has been approved by Medicare. Prior authorization of payment is not required. Documentation of Medicare coverage (remittance advice or coordination of benefits) must be submitted on or with the Medicaid claim when billing for the chair portion.

SHEETS, DISPOSABLE OR REUSABLE	Not covered-convenience item; not primarily medical in nature.
SHOWER ATTACHMENTS, HANDHELD	Not covered-hygienic equipment; not primarily medical in nature.
SITZ BATHS	Covered for clients with infection or injury of the perineal area and use of the item is part of the physician ordered planned regimen of treatment in the client's home.

Clients in Nursing Facilities and ICF/MR's: Sitz baths are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

SPEECH TEACHING

MACHINES Not covered-education equipment; not primarily medical in nature.

SPINAL ORTHOSES..... Covered when required to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured body part.

A seating system, back module for use with a wheelchair is covered when medically necessary for use with a medically necessary wheelchair base, for a client who has a diagnosed medical condition that impairs their ability to sit. A wheelchair seating system may be covered for the purpose of -

1. Supporting the client in a position that minimizes the development or progression of musculoskeletal impairment;
2. Relieving pressure; or
3. Providing support in a position that improves the client's ability to perform functional activities.

An evaluation of the client's wheelchair seating needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of wheelchair seating system; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Form MS-79 must be reviewed and signed by a physician involved in the client's care. Note: This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the wheelchair will be required on a short-term basis only.

Clients in Nursing Facilities and ICF/MR's: Spinal orthoses are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

Prior Authorization: Prior authorization of payment is required for orthotic seating systems and back modules incorporated in or attached to wheelchair bases. See 471 NAC 7-008 for prior authorization requirements.

STAIRWAY ELEVATORS Not covered-convenience item; not primarily medical in nature.

STOCKINGS, SURGICAL See SUPPORTS.

SUCTION PUMPS..... Covered for clients who have difficulty raising and clearing secretions secondary to -

1. Cancer or surgery of the throat or mouth;
2. Dysfunction of the swallowing muscles;
3. Unconsciousness or obtunded state; or
4. Tracheostomy.

Clients in Nursing Facilities and ICF/MR's: Suction pumps and related supplies/accessories are not covered for clients residing in nursing facilities or ICF/MR's.

Supplies/Accessories: Supplies and accessories necessary for effective use and proper functioning of a suction pump are covered for use with rented and client-owned suction pumps for clients whose condition meets the criteria for coverage of the pump.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Use of Medicare CMN form is strongly encouraged.

Prior Authorization: Prior authorization of payment is not required.

(See also TRACHEOSTOMY CARE SUPPLIES.)

SUPPORTS (including elastic supports, elastic/surgical stockings, slings, trusses, etc.).

Covered for post surgical clients, and clients with intractable edema of the lower extremities or other circulatory disorders.

Note: Support pantyhose are not covered.

Clients in Nursing Facilities and ICF/MR's: Supports, except surgical/anti-embolism stockings, are covered for clients residing in nursing facilities ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

TELEPHONE ALERT
SYSTEMS

Not covered-these are emergency communication systems and do not serve a diagnostic or therapeutic purpose.

TELEPHONE ARMS

Not covered-convenience item; not primarily medical in nature.

TOOTHBRUSHES

Not covered-personal hygiene item.

TRACHEOSTOMY CARE
SUPPLIES

Covered for clients with an open surgical tracheostomy.

A tracheostomy care or cleaning starter kit is covered following an open surgical tracheostomy for a two week post-operative period.

An artificial larynx is covered for clients that have had a laryngectomy or whose larynx is permanently inoperable.

Clients in Nursing Facilities and ICF/MR's: Coverage of tracheostomy care supplies for clients residing in nursing facilities and ICF/MR's is limited to artificial larynx and tracheostomy speaking valves.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

TRACTION EQUIPMENT Covered for clients with orthopedic impairments requiring traction equipment that prevents ambulation during the period of use.

Cervical pillows are covered only when required for use with traction equipment.

Clients in Nursing Facilities and ICF/MR's: Traction equipment and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase and rental of traction equipment includes all accessories necessary for proper functioning and effective use of the equipment. Accessories are payable only as replacement for use with client-owned traction equipment for clients whose condition meets the criteria for the equipment.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

TRANSCUTANEOUS
ELECTRICAL NERVE
STIMULATORS (TENS)

Covered for clients with chronic, intractable pain or acute post-operative pain who meet the following criteria -

The presumed etiology of the pain must be a type which is accepted as responding to TENS therapy.

For chronic, intractable pain, the medical record must document the location of the pain, the duration of time the patient has had the pain and the presumed etiology of the pain. The pain must have been present for at least 3 months.

Other appropriate treatment modalities must have been tried and failed and the medical record must document what treatment modalities have been used (including the names and dosage of medication), the length of time that each type of treatment was used and the results. The TENS unit must be used by the client on a trial basis for a minimum of one month, but not to exceed two months. This trial period may not begin sooner than the end of the 3 months used to establish the existence of chronic pain. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the client at the end of the trial period and must indicate how often the client used the TENS unit, the typical duration of use each time, and the results.

A TENS unit is not covered for acute pain (less than 3 months duration) other than post-operative pain. For acute post-operative pain, a TENS unit is generally covered for no more than one month following the day of surgery. Approval for more than one month will be determined on a case-by-case basis, based on the documentation provided by the attending physician and submitted with the prior authorization request.

A four-lead TENS unit may be used with either 2 lead or 4 leads, depending on the character of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the client's needs.

A conductive garment for use with a TENS unit may be covered when medical necessity is sufficiently substantiated.

Clients in Nursing Facilities and ICF/MR's: TENS units and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: TENS supplies are covered for use with rented and client-owned TENS units for clients whose condition meets the criteria for coverage of the unit. If the TENS unit is used less than daily, the frequency of billing for the TENS supplies must be reduced proportionally. For rented TENS units, the supplies must be billed on the same claim as the TENS rental.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is required for rental and purchase of TENS units. See 471 NAC 7-008 for prior authorization requirements.

TRANSFER EQUIPMENT Covered for clients that require assistance with transfer.

Clients in Nursing Facilities and ICF/MR's: Transfer equipment is not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

(See also LIFTS, PATIENT; WHEELCHAIR OPTIONS/ ACCESSORIES.)

TRAPEZE EQUIPMENT Covered when required for clients to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

Clients in Nursing Facilities and ICF/MR's: Trapeze equipment is not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

(See also HOSPITAL BED ACCESSORIES.)

ULTRAVIOLET CABINETS Covered for clients with generalized, intractable psoriasis. Documentation must justify treatment at home rather than alternative site (e.g., the outpatient department of a hospital).

Clients in Nursing Facilities and ICF/MR's: Ultraviolet cabinets are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is required for rental and purchase of ultraviolet cabinets. See 471 NAC 7-008 for prior authorization requirements.

URINALS See BEDPANS and URINALS.

UTERINE MONITORS,
HOME..... Covered on a rental basis for clients that meet the following criteria -

1. The client is at high risk for preterm labor and delivery and must be a candidate for tocolytic therapy;
2. The pregnancy must be greater than 20 weeks gestation; and
3. The client must have one of the following medical conditions -
 - a. Recent preterm labor with hospitalization and discharge on tocolytic therapy;
 - b. Multiple gestation;
 - c. History of preterm delivery;
 - d. Anomalies of the uterus;
 - e. Incompetent cervix;
 - f. Previous cone biopsy;
 - g. Polyhydramnios; or
 - h. Diethylstilbestrol exposure.

Others at high risk for preterm labor and delivery may be covered upon approval by the Medicaid Medical Director through written communication from the client's physician (preferably in consultation with a perinatologist).

Uterine monitoring is not covered after completion of the 36th week of pregnancy.

The following conditions must be met prior to provision of uterine monitors -

1. Comprehensive client assessment and evaluation by the attending physician has occurred; and
2. Client has successfully completed training on use of equipment.

Payment: NMAP rental payment includes all equipment, supplies and services necessary for the effective use of the monitor. This does not include medications or physician's professional services.

Provider Requirements: The provider must have an approved "Coordination Plan" for home uterine monitoring services (see 471 NAC 7-006).

Clients in Nursing Facilities and ICF/MR's: Uterine monitors and related supplies and services are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

Billing Requirements: The provider shall indicate on the claim the condition which necessitates use of the monitor and, when billing for the final rental period, the date of discontinuation of the monitor.

VAPORIZERS, ROOM

TYPE.....

Covered for clients with a respiratory illness. Coverage includes "cool mist" and "warm mist" vaporizers.

Clients in Nursing Facilities and ICF/MR's: Vaporizers are not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

VEHICLE, POWER-OPERATED

(POV)

A power-operated vehicle (POV) is covered instead of a manual wheelchair when all of the following criteria are met -

1. The client has a diagnosed medical condition which impairs their ability to walk;
2. The client requires a POV for the purpose of -
 - a. Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. They include, but are not limited to: caring for oneself, mobility, learning, working, performing manual tasks, breathing, seeing, and communicating; or
 - b. Providing assisted mobility for clients who show no means of safe independent mobility.
3. The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client's use of a POV must result in a significant improvement in independent mobility and ability to perform major life activities; and
4. The client has demonstrated, through a trial period with a similar POV -
 - a. the ability to safely and independently operate the controls of a POV;
 - b. the ability to transfer safely in and out of a POV; and
 - c. adequate trunk stability to be able to safely ride in the POV.

An evaluation of the client's wheelchair needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of POV as well as any options or accessories; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Form MS-79 must be reviewed and signed by a physician involved in the client's care. Note: This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the POV will be required on a short-term basis only.

Clients in Nursing Facilities and ICF/MR's: POV are covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with ~~for~~ all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

Prior Authorization: Prior authorization of payment is required for rental and purchase of power-operated vehicles. See 471 NAC 7-008 for prior authorization requirements.

VENTILATORS.....

Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, chronic respiratory failure consequent to chronic obstructive pulmonary disease and respiratory paralysis.

Clients in Nursing Facilities and ICF/MR's: Ventilators and related supplies/accessories are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for rental of ventilators includes all accessories necessary for proper functioning and effective use of the device. Accessories are payable only as replacement for use with client-owned ventilators for clients whose condition meets the criteria for the device.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

WALKERS..... Covered for clients with conditions that impair ambulation and there is a need for greater stability and security than provided by a cane or crutches.

A heavy duty, multiple braking system, variable wheel resistance walker is covered for clients who are unable to use a standard walker due to obesity, severe neurologic disorders, or restricted use of one hand.

Clients in Nursing Facilities and ICF/MR's: Walkers are not covered for clients residing in nursing facilities and ICF/MR's.

Supplies/Accessories: Payment for purchase and rental of walkers includes all accessories necessary for proper functioning and effective use of the item. Accessories such as tips, handgrips, etc., are payable only as replacement for use with client-owned walkers for clients whose condition meets the criteria for coverage of the item.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is not required.

WHEELCHAIRS,
(MANUAL and POWER) A manual wheelchair is covered for clients who meet the following criteria -

1. The client has a diagnosed medical condition which impairs their ability to walk; and
2. The client requires a wheelchair for the purpose of -
 - a. Increasing their independence with mobility, resulting in significant difference in their ability to perform major life activities. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. They include, but are not limited to: caring for oneself, mobility, learning, working, performing manual tasks, breathing, seeing, and communicating; or
 - b. Providing assisted mobility for clients who show no means of safe independent mobility.

A powered wheelchair is covered instead of a manual wheelchair if the client meets the criteria for a manual wheelchair and -

1. The client has significant limitation of limb function such that the client is not able to propel a manual wheelchair. Compared to their use of a manual wheelchair, the client's use of a powered wheelchair must result in a significant improvement in independent mobility and ability to perform major life activities; and
2. The client has demonstrated, through a trial period with a similar powered wheelchair, the ability to safely and independently operate the controls of a powered wheelchair.

An evaluation of the client's wheelchair needs by a licensed physical or occupational therapist is required. Documentation must be provided using Form MS-79 "Wheelchair and Wheelchair Seating System Selection Report", and must -

1. Justify the type of wheelchair as well as any options or accessories; and
2. Provide evidence of a coordinated assessment. A coordinated assessment includes communication between the client, caregiver(s), physician, physical and/or occupational therapist, and equipment supplier. The assessment should address physical, functional, and cognitive issues, as well as accessibility and cost effectiveness of equipment.

Form MS-79 must be reviewed and signed by a physician involved in the client's care. Note: This evaluation will generally not be required when the diagnosis or prescribed length of need indicates the wheelchair will be required on a short-term basis only.

Clients in Nursing Facilities and ICF/MR's: Non-standard wheelchairs needed for the client's permanent and full-time use may be covered for clients residing in nursing facilities and ICF/MR's.

Options/Accessories: Wheelchair options/accessories are covered when medically necessary for use with a medically necessary, rented or client-owned wheelchair base.

A wheelchair seating system is covered when medically necessary for use with a medically necessary wheelchair base, for a client who has a diagnosed medical condition that impairs their ability to sit. A wheelchair seating system may be covered for the purpose of -

1. Supporting the client in a position that minimizes the development or progression of musculoskeletal impairment;
2. Relieving pressure; or
3. Providing support in a position that improves the client's ability to perform functional activities.

A reclining back wheelchair frame is one in which the angle between the seat and the back of the frame is adjustable between 90 and 180 degrees. It may include elevating legrests. A reclining back may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

A tilt-in-space wheelchair frame is one in which the angle between the seat and the back remain relatively fixed, but the seat and back pivot as a unit away from the fully upright position, such that the angle that both the seat and back make with the ground is able to be adjusted, usually more than 30 degrees. A tilt-in-space wheelchair frame may be manually operated (by a caregiver) or power operated (usually by the wheelchair user).

Reclining back or tilt-in-space wheelchair frames are covered for clients that -

1. Have a diagnosed medical condition which impairs their ability to tolerate the fully upright sitting position for significant amounts of time (usually greater than two hours);
2. Need to remain in a wheelchair for purposes of mobility or other interaction with their environment; and
3. Require frequent, significant adjustment of their position in the wheelchair, either to change hip angle or their sitting position relative to the ground.

Power operation of the reclining or tilt-in-space mechanism, which may include power operated elevating legrests, is covered for clients that meet the criteria for a reclining or tilt-in-space mechanism and -

1. Have the cognitive and motor ability to operate the required control switch(es); and
2. Are routinely in situations (e.g., home, community, school, work, etc.) where caregivers are not available within a reasonable time to manually recline or tilt them as needed.

Combination power recline/tilt-in-space frames, if unavailable in manually operated forms, are covered for clients that require both recline and tilt-in-space features (e.g., lack of necessary passive hip flexion for use of a standard tilt-in-space or inability to tolerate a significantly greater hip extension angle during sitting).

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements. Form MS-79, "Wheelchair and Wheelchair Seating System Selection Report" is required with ~~for~~ all requests for prior authorization of wheelchairs, wheelchair options/accessories, and seating systems, unless the wheelchair will be required on a short term basis only. Form MS-79 must be completed by the licensed physical or occupational therapist who evaluated the client's wheelchair/seating system needs and reviewed and signed by a physician involved in the client's care. (See 471-000-208 for form and completion instructions.)

Prior Authorization: Prior authorization of payment is required for rental and purchase of wheelchairs and wheelchair options/accessories when included as an integral part of a wheelchair purchase or rental. See 471 NAC 7-008 for prior authorization requirements. Note: Requests for prior authorization must include the vendor specifications or order form which lists the type of wheelchair base, along with all options/accessories.

(See also SPINAL ORTHOSES - Seating Systems and Back Modules; Vehicles, Power Operated.)

WHIRLPOOL BATH
EQUIPMENT, STANDARD
(BUILT-IN TYPE)

Covered for clients who are homebound and have a condition for which the whirlpool bath is expected to provide substantial therapeutic benefit to justify its cost. Where the client is not homebound, but has such a condition, payment is restricted to providing the services elsewhere (e.g., an outpatient department of a hospital) if that alternative is less costly.

Clients in Nursing Facilities and ICF/MR's: Whirlpool bath equipment is not covered for clients residing in nursing facilities and ICF/MR's.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is required for whirlpool bath equipment. See 471 NAC 7-008 for prior authorization requirements.

WHIRLPOOL PUMPS,
PORTABLE

Not covered-not primarily medical in nature; generally used for soothing or comfort purposes.

NOT OTHERWISE CLASSIFIED ...
(NOC) CODES

Coverage of items for which no specific procedure code exists will be determined on a case-by-case basis.

Documentation: See 471 NAC 7-007 for documentation of medical necessity requirements.

Prior Authorization: Prior authorization of payment is required for rental and purchase of durable medical equipment not otherwise classified if the purchase price of the item exceeds \$500. See 471 NAC 7-008 for prior authorization requirements.